Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HORIZON EVALUATORS INC
11058 REGENCY GREEN DRIVE
CYPRESS TX 77429-4757

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
ACE AMERICAN INSURANCE CO

Carrier's Austin Representative Box
Box Number 15

MFDR Tracking Number
M4-12-2907-01

MFDR Date Received
MAY 14, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Request for Reconsideration: "We only bill for the Lumbar Sprain/Strain. We only bill for the Lumbar Sprain & Strain ICD-9 Code 847.2. …we receive Pre-Authorization approval for the initial 10 sessions of a Chronic Pain Management Program and render services." "*The chronic pain management program was preauthorized and per the Texas Department of Insurance statute 413.014(e) 'if a specified health care treatment or service is preauthorized as provided by this section, that treatment or service is not subject to retrospective review of the medical necessity of the treatment or service', this is also stated in rule 133.240."*

Amount in Dispute: $8,640.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "ESIS maintains its denial of services billed for 02/01/2012 – 02/08/2012 as a peer review opines that the chronic pain management program is not related to the compensable injury of a soft tissue lumbar strain."

Response Submitted by: ACE ESIS

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 1 through 8, 2012	Chronic Pain Management Program	$8,640.00	$ 4800.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for preauthorization, concurrent review, and

voluntary certification of health care.

3. 28 Texas Administrative Code §134.204 sets out the fee guidelines for the reimbursement of workers' compensation specific codes, services and programs provided on or after March 1, 2008.
4. The services in dispute were reduced/denied by the respondent with the following reason code:

   Explanation of benefits
   - 219 – based on extent of injury

Issues

1. Did the respondent support its denial reason?
2. Did the requestor obtain preauthorization for the services in dispute?
3. Is the requestor entitled to reimbursement?

Findings

1. The respondent denied the disputed services based upon extent of injury. The carrier's submitted PLN-11 acknowledges a soft tissue muscle strain/lumbar strain. The requestor billed with diagnosis code 847.2 – lumbar sprain and strain. The respondent's denial reason 219 is not supported; therefore, pursuant to 28 Texas Administrative Code §133.307(a)(3), the Division will adjudicate the payment in accordance with 28 Texas Administrative Code §134.204.

2. The requestor submitted a copy of preauthorization #109070 dated December 15, 2011 which states, "This correspondence serves as notification that the requested medical treatment listed below meets established criteria for medical necessity based on our review of the information submitted – 80 hours of chronic pain management program between 12/12/11 and 2/10/12." 28 Texas Administrative Code §134.600(c) states "The carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur: (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care."

3. Reimbursement is recommended in accordance with 28 Texas Administrative Code §134.204(h)(5) which states that reimbursement for a chronic pain management program shall be $125.00 per hour. 28 Texas Administrative Code §134.204(h)(1)(B) further states that the hourly reimbursement for non-CARF accredited programs shall be 80 percent of the MAR. Eight hours per day at $100.00 per hour equals $800.00 times six days equals $4800.00. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $ 4800.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $4800.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October , 2012 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.